

UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

PATIENT ADVOCATES, LLC,)
)
 Plaintiff)
)
 v.)
)
 ALAN M. PRYSUNKA,)
)
 Defendant)

Docket No. 03-118-P-H

**RECOMMENDED DECISION ON DEFENDANT’S MOTION FOR SUMMARY
JUDGMENT**

The defendant, Alan M. Prysunka, who is sued in this action arising under the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1001 *et seq.*, only in his official capacity as executive director of the Maine Health Data Organization (MHDO), moves for summary judgment on all claims asserted in the amended complaint. I recommend that the court grant the motion.

I. Summary Judgment Standard

Summary judgment is appropriate only if the record shows “that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” Fed. R. Civ. P. 56(c). “In this regard, ‘material’ means that a contested fact has the potential to change the outcome of the suit under the governing law if the dispute over it is resolved favorably to the nonmovant. By like token, ‘genuine’ means that ‘the evidence about the fact is such that a reasonable jury could resolve the point in

favor of the nonmoving party.” *Navarro v. Pfizer Corp.*, 261 F.3d 90, 93-94 (1st Cir. 2001) (quoting *McCarthy v. Northwest Airlines, Inc.*, 56 F.3d 313, 315 (1st Cir. 1995)).

The party moving for summary judgment must demonstrate an absence of evidence to support the nonmoving party’s case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). In determining whether this burden is met, the court must view the record in the light most favorable to the nonmoving party and give that party the benefit of all reasonable inferences in its favor. *Nicolo v. Philip Morris, Inc.*, 201 F.3d 29, 33 (1st Cir. 2000). Once the moving party has made a preliminary showing that no genuine issue of material fact exists, the nonmovant must “produce specific facts, in suitable evidentiary form, to establish the presence of a trialworthy issue.” *Triangle Trading Co. v. Robroy Indus., Inc.*, 200 F.3d 1, 2 (1st Cir. 1999) (citation and internal punctuation omitted); Fed. R. Civ. P. 56(e). “As to any essential factual element of its claim on which the nonmovant would bear the burden of proof at trial, its failure to come forward with sufficient evidence to generate a trialworthy issue warrants summary judgment to the moving party.” *In re Spigel*, 260 F.3d 27, 31 (1st Cir. 2001) (citation and internal punctuation omitted).

II. Factual Background

The following undisputed material facts have been appropriately submitted by the parties in accordance with this court’s Local Rule 56.

The defendant is the executive director of MHDO and has served in that position since September 15, 1997. Defendant’s Statement of Material Facts in Support of His Motion for Summary Judgment (“Defendant’s SMF”) (Docket No. 19) ¶ 1; Plaintiff’s Statement of Material Facts (“Plaintiff’s Responsive SMF”) (Docket No. 21) ¶ 1. MHDO was established in 1995 by the Maine Legislature and is charged “to create and maintain a useful, objective and comprehensive health information database” designed to improve the health of Maine citizens. *Id.* ¶ 2. The statute that created MHDO requires that the database be

“publicly accessible while protecting patient confidentiality and respecting providers of care.” *Id.* MHDO is required to collect, process and analyze clinical and financial data submitted by health care providers and health payers subject to its jurisdiction. *Id.* MHDO is principally funded by assessments levied on nonprofit hospital and medical service organizations, health insurance carriers and health maintenance organizations, third-party administrators and carriers that provide administrative services only for health care plan sponsors, and non-hospital health care providers. *Id.* ¶ 3. MHDO derives approximately 98% of its operating revenues from these assessments. *Id.*

The Maine Legislature establishes the maximum aggregate level of annual assessments that MHDO may impose. *Id.* ¶ 4. For fiscal year 2002, the Maine Legislature significantly increased the total authorized level of assessments that the MHDO could impose to \$1,346,904. *Id.* ¶ 5.

Maine law requires all third-party administrators licensed to do business in Maine to report to the Superintendent of Insurance for the most recent calendar year all covered individuals in the state of Maine by the total number of health claims paid by the administrator by each plan sponsor and the total dollar amount of health claims paid by each plan sponsor. *Id.* ¶ 7. The Superintendent of Insurance provides MHDO with the financial information reported by third-party administrators. *Id.* ¶ 8.

The plaintiff contracts with various health care plans whereby it agrees to provide services to those plans, including ERISA compliance, processing of claims, payment of claims, appeals processing and related functions. Additional Statement of Material Facts (“Plaintiff’s SMF”) (included in Plaintiff’s Responsive SMF beginning at [3]) ¶ 1; Defendant’s Response to Plaintiff’s Statement of Additional Material Facts (“Defendant’s Responsive SMF”) (Docket No. 25) ¶ 1. The contracts are contained in an administrative services agreement which the plaintiff and each of the plans have executed. *Id.* ¶ 2. All but one of the plans with which the plaintiff contracts are subject to the provisions of ERISA. *Id.* ¶ 3. ERISA

plans are administered by fiduciaries which have the legal obligation to administer the plans for the exclusive benefit of the plans' participants and beneficiaries. *Id.* ¶ 4. The plaintiff is not a fiduciary with regard to its ERISA plan clients. *Id.* ¶ 5. It is a "contract administrator" that assists ERISA fiduciaries in administering their plans. *Id.* In providing services to the plans, the plaintiff obtains certain information from the plans, as well as third-party providers of health services to the plans' covered participants, including the name, address, social security number, age and medical history of participants; health treatment received; names of physicians; results of tests; amount of claims paid; etc. *Id.* ¶ 6. The plaintiff uses various iterations of this information to process claims for, as well as to provide ERISA compliance advice to, the plans. *Id.* ¶ 9.

As part of its statutory charge, MHDO requires third-party administrators, including the plaintiff, to provide it with certain data compiled from such information. *Id.* ¶ 10. The data must be filed annually, in a certain format. *Id.* ¶ 11. In order to be re-licensed annually by the Maine Bureau of Insurance, the plaintiff is required to report the amount and number of claims paid out on behalf of each plan. *Id.* ¶ 12. The plaintiff provided such information to the Bureau of Insurance only after seeking and receiving written consent from the plans. *Id.* ¶ 13.

In early August 2002 the plaintiff informed the Superintendent of Insurance that it would not report the financial data required by 24-A M.R.S.A. § 1906(4) and asserted that the statute was pre-empted by ERISA. Defendant's SMF ¶ 9; Plaintiff's Responsive SMF ¶ 9. In early September 2002 MHDO imposed its assessments upon entities subject to its jurisdiction for fiscal year 2003. *Id.* ¶ 10. On October 25, 2002 the defendant attended a meeting with representatives of the plaintiff and the Bureau of Insurance to discuss the plaintiff's refusal to submit financial information to the Bureau of Insurance. *Id.* ¶ 11. Subsequently, the plaintiff advised the defendant of its gross medical and dental claims paid on behalf of its clients during 2001 and filed the required form with the Bureau of Insurance. *Id.* On April 30, 2003 the

plaintiff filed with the Bureau of Insurance the relevant form containing financial information for the claims it processed in 2002. *Id.* ¶ 12. Based on the data reported by the plaintiff, MHDO imposed on the plaintiff assessments of \$3,498 for fiscal year 2002-03 and \$3,154 for fiscal year 2003-04. *Id.* ¶ 14. The plaintiff paid its assessment for fiscal year 2002-03 but has not paid its assessment for fiscal year 2003-04. *Id.* ¶ 15.

MHDO has delegated the responsibility for gathering health care claims data from entities subject to MHDO data reporting requirements to the Maine Health Data Processing Center. *Id.* ¶ 16. On November 27, 2002 the plaintiff registered on-line with the Processing Center to begin the process of submitting claims data. *Id.* ¶ 17. On April 17, 2003 the plaintiff informed MHDO that it would not report health care claims data, maintaining that the law requiring such submissions was preempted by ERISA. *Id.* ¶ 18. The plaintiff has never submitted any health care claims data to MHDO or the Processing Center. *Id.* The plaintiff did not provide MHDO with the data because, despite making a request, it did not receive consent to do so from the ERISA plans. Plaintiff's SMF ¶ 14; Defendants' Responsive SMF ¶ 14. Some of the ERISA plans pay benefits to beneficiaries in states other than Maine. *Id.* ¶ 16.

MHDO has adopted policies and procedures to safeguard the privacy, security and integrity of individually identifiable health information consistent with the requirements of rules adopted pursuant to the Health Insurance Portability and Accountability Act of 1966 ("HIPAA"). Defendant's SMF ¶ 21 Plaintiff's Responsive SMF ¶ 21. MHDO has adopted rules designed to protect the privacy of individually identifiable health information reported to it by entities subject to its health care claim data reporting requirements. *Id.* ¶ 22. The administrative services agreements that each of the plaintiff's ERISA clients entered into with the plaintiff expressly permit the plaintiff to disclose claims data or other plan information as required by law. *Id.* ¶ 28. The agreements define "required by law" to mean "a mandate contained in law that compels a

covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law . . . [and i]ncludes statutes or regulations that require the production of information.” *Id.* ¶ 31.¹

III. Discussion

The amended complaint includes four counts, three of which assert that Chapter 1683 of Title 22 of the Maine Revised Statutes Annotated is pre-empted by ERISA. Amended Complaint (Docket No. 11) ¶¶ 19,² 23, 31. Count One alleges that this pre-emption exists “to the extent that [the statutes] require[] an entity to provide Data derived from Plan Information owned by an ERISA Plan without the consent of the ERISA Fiduciary that owns the Plan Asset.” *Id.* ¶ 19. Count Two alleges that this pre-emption exists “to the extent that [the statutes] require[] an entity to pay Data Fees based on Claims Information owned by an ERISA plan.” *Id.* ¶ 23. Count Three alleges that the information at issue constitutes assets of the ERISA plans and that the statutes are pre-empted by ERISA “to the extent that [they] require[] the transfer of Plan Assets to MHDO.” *Id.* ¶ 31. The defendant contends that he is entitled to summary judgment on Counts One and Three because the information at issue does not constitute “plan assets” and on Count Two because the assessment does not constitute impermissible interference with an ERISA plan. Defendant’s Motion for Summary Judgment, etc. (“Motion”) (Docket No. 18) at 3-4. The plaintiff responds that its claims are based on assertions both that the information at issue is an asset of the ERISA plans and that the gathering and collating of the data required by the statutes “relates to” ERISA plans. Plaintiff’s Opposition to Defendant’s Motion for Summary Judgment (“Opposition”) (Docket No. 20) at 5.

The relevant section of ERISA provides as follows:

¹ The plaintiff’s response to this paragraph purports to be a qualification, although it is expressed more in the manner of an objection: “The statements in number 31 constitute legal arguments.” Plaintiff’s Responsive SMF ¶ 31. Paragraph 31 quotes from a number of apparently identical documents. Such quotations do not constitute legal argument.
² Each of my references to paragraphs 19 or 20 of the amended complaint will be to the second paragraphs so numbered in (continued on next page)

(a) Supersedure . . .

Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan

(b) Construction and application

* * *

(2)(A) . . . [N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(a) & (b).

MHDO was created to “create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens.” 22 M.R.S.A. § 8703(1). It was directed by the Maine Legislature to “establish uniform reporting systems” for the “collection, processing, storage and analysis of clinical, financial, quality and restructuring data.” 22 M.R.S.A. § 8704(1)(A). It was also directed to exempt from reporting by a provider data regarding a person who informs the provider of that person’s objection. 22 M.R.S.A. § 8704(1)(E). It was authorized to adopt rules. 22 M.R.S.A. §§ 8704(4), 8705(1). Failure to comply with the reporting requirements may subject those required to report to fines, court action and licensing action. 22 M.R.S.A. § 8705(2), (3). MHDO is authorized to collect annual assessments from those entities required to report. 22 M.R.S.A. § 8706(2).

The parties are less than clear in their arguments about the provision of ERISA that presumably prevents the transfer of “plan assets,” the prohibition of which apparently provides the basis for Count Three. Opposition at 5. The plaintiff cites *Acosta v. Pacific Enters.*, 950 F.2d 611 (9th Cir. 1991), in support of its argument on this point, Opposition at 8-9, and that opinion identifies 29 U.S.C. § 1106(b)(1)

that document.

as the prohibition at issue, 950 F.2d at 620.³ That section of ERISA provides: “A fiduciary with respect to a plan shall not — (1) deal with the assets of the plan in his own interest or for his own account.” 29 U.S.C. § 1106(b)(1). The parties have agreed that the plaintiff is not a fiduciary with respect to the plan at issue. Plaintiff’s SMF ¶ 5; Defendant’s Responsive SMF ¶ 5. Thus, it appears that the statute does not apply to the plaintiff at all, and the considerable time and effort the parties have devoted to a discussion of whether the information sought by MHDO is a “plan asset” addresses a moot point. In the absence of any further indication by the plaintiff of how the Maine statutes at issue require transfer of plan assets in violation of ERISA, the defendant is entitled to summary judgment on any claim based on this theory.

The plaintiff also contends that Count Three asserts a claim that the state statutes, or the regulations implementing those statutes, “relate to” ERISA through the ownership of plan assets. Opposition at 7. “[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.” *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000). The only such “clear manifestation” of a purpose that could make the Maine statutes and regulations at issue subject to preemption identified by the plaintiff, Opposition at 6, is the First Circuit’s formulation, issued four days after the opinion in *Pegram*, to the effect that

[w]hen Congress conceived the ERISA scheme, it made manifest its intention to “protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies.” 29 U.S.C. § 1001(b). Achieving this end requires the avoidance of “a multiplicity of regulation” and, concomitantly, the creation of a climate that “permit[s] the nationally uniform administration of employee benefit

³ The plaintiff asserts that “ERISA preempts the transfer of any ‘Plan Asset’ without the Plan’s consent,” Opposition at 7, but cites no authority in support of this assertion. A careful reading of the plaintiff’s memorandum of law reveals no other possible authority for the assertion. Under these circumstances, the court will not look beyond the statutory authority cited in the case law cited by the plaintiff.

plans.” [*New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers [Ins. Co]*, 514 U.S. [645,] 657 [1995].

Carpenters Local Union No. 26 v. United States Fid. & Guar. Co., 215 F.3d 136, 140 (1st Cir. 2000). A “meaningful nexus with ERISA” may arise when a statute or regulation “interfere[s] with the administration of covered employee benefit plans, purport[s] to regulate plan benefits, or impose[s] additional reporting requirements.” *Id.* at 141. Only the last of these potential points of relation is relevant to the statutes and regulations at issue in this case.⁴ Even with respect to this point, the plaintiff bears “the considerable burden” of overcoming the presumption that Congress did not intend to supplant state law. *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997).

The First Circuit cited no authority in *Carpenters* for its inclusion of additional reporting requirements on the list cited above. It did analyze the statutory provision alleged to be preempted in light of its actual operation and found important the facts that the statute did not impose requirements on ERISA plans as such and that the statute applied to “a wide variety of situations, including an appreciable number that have no specific linkage to ERISA plans,” making it a law of general application. 215 F.3d at 144. A statute of general application that imposes “some burdens on the administration of ERISA plans” does not “relate to” those plans within the meaning of ERISA. *Id.* at 145, citing *DeBuono*, 520 U.S. at 815. That seems to be the case here. The statutes at issue require reporting by “providers,” a term that is defined to include “a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy,” and “payors” defined as “a 3rd-party payor or 3rd-party administrator,” each of which is further defined to include persons both affiliated with and not affiliated with health care plans. 22 M.R.S.A.

⁴ The statute and regulations at issue do not interfere with the administration of the plans served by the plaintiff because they do not “specify the mode or manner of plan administration.” *Carpenters*, 215 F.3d at 144. The plaintiff does not contend that they regulate plan benefits.

§§ 8702(8), (9), (10-A), (11); 8704(1)(C). The statutes and their implementing regulations apply to a large number of entities that have no specific linkage to ERISA plans and impose some burdens on the administration of ERISA plans in terms of reporting requirements,⁵ but they are not thereby “related to” ERISA plans. *DeBuono*, 520 U.S. at 814-16. Nothing in the language of ERISA itself is contrary to the state statutes at issue, and the plaintiff cites no federal ERISA regulation that is contrary to any provision of the state statutes. *See* 45 C.F.R. § 160.203.⁶ I conclude that the defendant is entitled to summary judgment on Counts One and Three of the amended complaint.

Count Two deals with the monetary assessment imposed by the Maine statutes at issue. The plaintiff contends that, even if the “regulatory scheme” at issue is not preempted, the fees “directly ‘relate to’ ERISA plans because the fees are calculated based on the amount of claims paid by ERISA plans.” Opposition at 11. As was the case with the reporting requirements, the fees at issue are assessed against all reporting entities, not just ERISA plans or those that provide administrative services to ERISA plans. 22 M.R.S.A. § 8706(2)(C). In *Travelers*, the Supreme Court held that state-imposed surcharges on patients and HMOs, collected by hospitals, “regardless of whether the commercial coverage of membership, respectively, is ultimately secured by an ERISA plan,” did not relate to ERISA plans for purposes of preemption. 514 U.S. at 649, 656. “An indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself.” *Id.* at 659. “Nor does

⁵ My own research has located no reported cases in which “reporting requirements” imposed by state statute provided the basis for a finding of ERISA preemption. The case commonly cited in dicta in support of this alternative, *Standard Oil Co. of California v. Aghsalud*, 633 F.2d 760 (9th Cir. 1980), mentions reporting requirements only in passing, *id.* at 763, and does not deal with the issue at all. The Supreme Court made clear in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), that ERISA’s concern with reporting requirements was that plans be subject to “a set of standard procedures to guide processing of claims and disbursement of benefits,” *id.* at 9. The Maine statutes at issue here do not affect either.

⁶ The fact that, as the defendant points out, Motion at 7-9, Reply Brief of Defendant, etc. (Docket No. 24) at 4-5, the plaintiff’s position is inconsistent with the provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations governing the disclosure and use of health care information, *see, e.g.*, 45 C.F.R. (continued on next page)

the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one.” *Id.* at 660.

The plaintiff attempts to distinguish *Travelers* by asserting that the fees imposed by the Maine statute “do function as a regulation of an ERISA plan itself.” Opposition at 13. This is so, apparently, because “the fee is imposed based on claims paid by plans, including the ERISA Plans, and the funds are used to support the MHDO, whose purpose is to obtain the Data.” *Id.* This statement is not helpful; it provides no basis upon which to distinguish *Travelers*. At best, it is an attempt to re-introduce the theory that the data reporting requirements of the statute are themselves preempted by ERISA, a proposition that I have already rejected.

The defendant is entitled to summary judgment on Count Two as well.

Count Four, the final count of the amended complaint, apparently asserts a claim under state law. Amended Complaint ¶¶ 34-38. The defendant asks this court to dismiss any state law claims pursuant to 28 U.S.C. § 1367(c)(3). Motion at 17. The plaintiff does not respond to this request. The cited statute provides that a federal district court may decline to exercise jurisdiction over a claim arising under state law when it has dismissed all claims over which it has original jurisdiction. This case presents an appropriate instance for dismissal of any state-law claims under section 1367. *See Pew v. Scopino*, 904 F. Supp. 18, 32 (D. Me. 1995).

IV. Conclusion

§ 164.512, supports my conclusion, although it is not determinative.

For the foregoing reasons, I recommend that the defendant's motion for summary judgment be **GRANTED** as to all federal claims asserted in the amended complaint and that any state-law claims asserted in the action be **DISMISSED**.

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) for which de novo review by the district court is sought, together with a supporting memorandum and request for oral argument before the district judge, if any is sought, within ten (10) days after being served with a copy thereof. A responsive memorandum and any request for oral argument before the district judge shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to de novo review by the district court and to appeal the district court's order.

Dated this 21st day of January, 2004.

/s/ David M. Cohen
David M. Cohen
United States Magistrate Judge

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